APPENDIX IV: TWO-PAGE SUMMARIES OF THE NINE OPTIONS PAPERS

HEALTHY CALIFORNIA:
A PROPOSAL FOR UNIVERSAL HEALTH INSURANCE COVERAGE IN CA

E. Richard Brown, PhD
UCLA Center for Health Policy Research and UCLA School of Public Health

Richard Kronick, PhD
Department of Family and Preventive Medicine, UCSD School of Medicine

Major Objectives the Healthy California Program Will Achieve

- Healthy California will **cover all citizens and legal immigrants residing in California** and give each of them a **choice of public or private coverage**.

  Many will continue to obtain employer-sponsored coverage, as they do now. However, all legal residents in California will be able to obtain publicly sponsored coverage through Healthy California — with no premium payment at the time of enrollment.

- Healthy California will **maximize federal matching dollars** available to California.

  Healthy California will be built on a foundation of the Healthy Families and Medi-Cal programs, integrated into a new, streamlined program in Stage 1 — but without the onerous eligibility application process now required.

- By using a pay-or-play approach, California **reduces barriers that federal law and politics pose** to other universal coverage proposals.

  The pay-or-play approach avoids the barrier that ERISA poses to state reforms that try to require employers to help pay for coverage. By maximizing federal matching funds and using the pay-or-play approach — mixed public-private financing, Healthy California minimizes the amount of revenue that must be shifted from employment-based payments to taxes.

Target Populations and Eligiblity

- All citizens and legal immigrants residing in California are eligible for Healthy California.

- Many undocumented immigrants will continue to receive coverage through employers who “play” or continue to receive care from private providers or the health care safety net.

Mechanism for Expanding Coverage

- In Stage 1, a federal waiver will enable the state to cover low-income adults without custodial children. Integration and streamlining of public programs will encourage all eligible children and adults to enroll.

- In Stage 2, **employers** would have to **choose** whether to **"play"** (provide private coverage) or **"pay"** (pay a premium as a percentage of payroll to the state program). **Employees choose** whether to **accept their employer's coverage**, if it is offered. All Californians not covered by other qualifying insurance will be eligible to **enroll in Healthy California** — without premium payment at the time of enrollment.

Delivery System and Administration

- Healthy California will be administered by the Major Risk Medical Insurance Board (MRMIB). MRMIB will conduct outreach to potentially eligible persons, determine eligibility of applicants, and monitor and assure quality, including ensuring that culturally competent services are available.

- MRMIB may contract with HMOs and directly with health care providers. Healthy California will also offer a PPO network option for a modest additional charge.

Health Benefits

- Healthy California will establish a state standard for benefit packages (SSBP), approximating the Healthy Families benefits as the benchmark. All residents will receive these benefits whether covered through Healthy California or through qualifying job-based insurance.

- Those who would currently be eligible for Medi-Cal will receive expanded benefits through "Healthy California+Plus." In addition to these additional benefits, they will not be charged copays that exceed those currently allowed by the Medi-Cal no-share-of-cost program.

Financing Mechanism

- In Stage 1, Healthy California will maximize federal matching funds for Medi-Cal and Healthy Families, and cap the rate of growth in spending to two percentage points less than currently projected under Medi-Cal and Healthy Families. Other sources of funding are being identified.

- In Stage 2, Healthy California will, in addition to Stage 1 financing, make all families eligible for federal match without regard to income and assets, receive payroll premium tax payments from employers and employees for all workers not covered through the workplace, and reduce administrative costs. Other sources of funding are being identified.

THE MANAGED CARE EXPANSION PROGRAM
A Project of Working Partnerships USA:
B. Brownstein, S. Zimmerman, L. Auerhahn, S. Muller, M. Elliot, W.K. Lum

Major Objectives:
The Managed Care Expansion Program (MCEP) seeks to provide affordable health insurance to low income, uninsured California residents primarily through a long-term, incremental expansion of public managed care programs. This approach is based on the view that both fiscal and political considerations make a large scale, rapid and fundamental change in health insurance options unlikely. At the same time, the MCEP seeks to attempt to improve the fiscal stability and sustainability of "safety net" institutions in the health care delivery system.

Target Populations
The MCEP will target uninsured Californians with annual incomes of 400% or less of the Federal Poverty Level. An eligible applicant must: be a California resident; be under the age of 65; be ineligible for other public health insurance programs including Medi-Cal and Healthy Families; and must have been uninsured for at least six months prior to enrollment (with the exception of those losing job-based insurance due to layoffs) *or* have access only to a substandard health insurance program. Undocumented immigrants will be eligible for coverage. The target population of the MCEP is estimated at approximately 3.2 million adults and 350,000 children.

Mechanism for expanding coverage
The MCEP will build on existing public sector institutions currently engaged in providing coverage through the Medi-Cal and Healthy Families programs. The reliance on public institutions is based on the dual goal of ensuring quality of service and supporting safety net providers. Because of regional differences and varying patterns of existing institutional frameworks, the specific form that the MCEP will take will be tailored to each county's infrastructure and demographics.

In counties that currently have a managed care system in place (such as Two-Plan and COHS counties), the existing system will be expanded. In Geographic Managed Care counties, plans will be offered the opportunity to bid to participate in the MCEP program for the county. If necessary, more than one plan may be chosen in order to provide coverage for all of the disparate communities in the county. In counties with other Managed Care models, the state will negotiate with the county to agree on an appropriate structure. In each Fee-For-Service county the state will assess whether the MCEP is feasible. Where managed care is not feasible and unlikely to improve the quality of care, FFS will remain and MCEP providers will receive reimbursement rates equal to those of Healthy Families. In all cases, MCEP plans must include traditional and safety net providers in the provider network.

Delivery System
The MCEP plans will market insurance coverage based on the number of new participants authorized by the state budget decisions. The program will initially cover the lowest income Californians and incrementally reach those approaching 400% of Federal Poverty Level. The Managed Risk Medical Insurance Board (MRMIB), already experienced with oversight of similar programs, will administer the MCEP.

Health Benefits
The MCEP benefits package will mirror the Healthy Families benefits package for both children and adults. Coverage will include:

a) Inpatient, outpatient, medical and surgical services
b) Prescription drugs, X-ray services, speech therapies
c) Mental health, dental and vision care

To encourage public use of preventive care, preventive services would be free to all users. Co-payments will range from $5 to $10 monthly for all other services, with an annual maximum of $250. Prescription drug co-payments range from $0 to $5 and are included in the annual $250 maximum.

Financing mechanism
Approximately 83% of the cost of the MCEP will be paid by the state. To contain these costs, the MCEP will implement a sliding scale through which individuals or their employers contribute to premium costs. Sliding scale payments will not exceed two and a half percent of annual household income, thereby limiting the extent to which payments are a barrier to enrollment. The MCEP sliding scale fees are as follows:

- Adults with household incomes under 100% of FPL pay no fee.
- Adults with incomes between 100% and 250% of FPL pay 1.5% of annual household income.
- Adults with incomes between 250% and 400% of FPL pay 2.5% of annual household income.
- Parents pay $9 per month for each enrolled child up to a maximum of $27 per month.

The incremental financing strategy for MCEP is designed to significantly expand health coverage while recognizing constraints on the state's fiscal capacities. In a model financing plan, increased allocations of state funds to the MCEP would be appropriated at approximately the same level for each of the next 15 years. With the estimated cost of $5.94 billion annually to cover the entire target population (without factoring in inflation), this would require an annual funding increment of approximately $396 million (as of 2000, in 2000 dollars). The actual cost to the state may be considerably lower, however, as this estimate reflects the maximum cost based on 100% enrollment, which is higher than enrollment estimates currently predict. For example, one prediction estimates 70% enrollment, which would result in a final cost of approximately $4.16 billion annually, with $277 million annual increments.

Thus, the MCEP plan attempts to provide the Governor and State Legislature with the ability to move slowly and consistently towards achieving universal health insurance in California without fundamentally restructuring the state's health care delivery system.

THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM (CPPP)
Health Policy R&D: Peter Harbage, Katie Horton, Jennifer Ryan

Program Goal

The California PacAdvantage Premium Program (CPPP) is designed to continue and supplement the significant efforts at providing health coverage to uninsured families in California. CPPP seeks to help small businesses make health insurance available to employees and their families. Small businesses face unique challenges in offering health insurance as compared to large businesses. Coupled with PacAdvantage, the state's existing non-profit small business purchasing pool, CPPP would offer premium assistance to employers and employees in paying for the costs of group health coverage.

Eligibility for CPPP

Employees

CPPP would make subsidized coverage available to workers with family incomes below 350 percent of the federal poverty level ($61,775 for a family of four in 2001):

- Individuals could be part-time employees, but must be working at least 20 hours per week.
- Applicants must have been uninsured for the previous six months before enrollment (unless employed by a firm already offering coverage through PacAdvantage); and
- Families must be ineligible for Medi-Cal and Healthy Families (as determined by a screening at the time of application).

Employers

Small businesses with between 2 and 50 employees could participate in CPPP, provided they:

- Meet the requirements for participation in PacAdvantage/CPPP;
- Have not offered health coverage (other than through PacAdvantage) in the previous 6 months;
- Purchase and offer coverage that is actuarially equivalent to the CPPP benchmark benefit package.

Premium Subsidy

Subsidies would be provided on a sliding scale based on the family's income level (expressed as a percentage of the federal poverty level):

Employee Income Level	Subsidy	Employer	Employee*	Total
350+	0	60	40	100
300 - 349	25	40	35	100
250-299	35	40	25	100
200 - 249	45	40	15	100
Below 200	55	35	10	100

Benefit Package and Cost Sharing

Employers would have two options for ensuring the purchase of a quality health insurance product. They could:

- Utilize the existing PacAdvantage purchasing pool, which would include a choice of nine different health plans in various parts of the state. CPPP employers would also have the option of providing dental, vision and other ancillary services.

- Purchase a benefits package that is actuarially equivalent to one of three benchmarks – any plan available through the most popular commercial HMO in the state; the federal employees health benefit plan as offered in California (FEHBP); or the richest PacAdvantage plan in the employers' area.

Cost sharing would be determined according to the requirements of the selected health plan. There would be no specific limits beyond those on the premiums. (It should be noted that because families must be screened for Medi-Cal and Healthy Families eligibility before enrolling in CPPP, most families would be at income levels between 250 and 350 percent of the FPL.)

Administration and Financing
PacAdvantage (managed by the Pacific Business Group on Health) would have responsibility for the daily operations of CPPP, with policy oversight and assistance from the Managed Risk Medical Insurance Board (MRMIB). This logical partnership would blend two successful and experienced entities to ensure an efficient and accountable premium assistance program.

CPPP would be financed by a combination of funding sources including an increase in taxes on tobacco and possibly alcoholic beverages. An outreach campaign would also be targeted at obtaining donations from foundations or other private funding sources.

Transition/Implementation Issues
One of the strongest aspects of CPPP is its inherent connection to the existing structure of PacAdvantage. The fundamental aspects of PacAdvantage would remain in tact and serve to strengthen the ability of small businesses to offer health coverage for their employees.

Establishing an income-based enrollment process (with the help and experience of MRMIB) along with establishing a strong outreach and marketing plan would be two important challenges for the program. However, the absence of a federal regulatory burden would make the program both practically and politically viable and would provide a great opportunity for innovation and significant progress toward covering California's uninsured population.

SINGLE PAYER HEALTH PROGRAM FOR CALIFORNIA

Kahn JG, Bodenheimer T, Grumbach K, Farey K, Lingappa V, McCanne D

1. Major objectives

- provide universal coverage through universal eligibility;
- cover all individuals in a single financing pool;
- provide a comprehensive benefit package;
- maintain overall health care spending at or below current (projected) levels, but use substantial administrative savings to fund expanded services;
- leave clinical decision-making with providers and patients, by using global financing rather than individual provider utilization review to control spending;
- improve quality of care through improved data and analysis of health care patterns and outcomes;
- foster advances in public health and prevention and in innovative technologies through earmarked funding; and
- improve public responsiveness of the health care system through public hearings and accountability to the electorate.

2. Target populations and eligibility

Single payer has no specific target populations; a primary principle is to provide **universal coverage**. This inclusive approach permits maximum administrative savings, and assures broad support for the system.

Eligibility is based on residence in California. All state residents are eligible for coverage after a 3-month waiting period; longer length-of-residency restrictions apply for certain services (e.g., long-term care 3 years). Individuals lacking legal immigration status (i.e., “undocumented”) are included if they can document residence. Emergency services are covered during the waiting period.

3. Mechanism for expanding coverage

Coverage is expanded by **documenting evidence of residence** in the state (e.g., employment papers, official correspondence, etc). **Implementation** is by a concerted campaign involving public service advertising, workplace benefits information, enrollment at health care providers and at government offices (e.g., social service agencies and the DMV), etc. Expanded coverage will be achieved quickly due to broad and simple eligibility rules; lack of public assistance stigma; absence of requirement for regular recertification; lack of significant financial burden to participants; and presumptive eligibility of impaired individuals.

4. Delivery system, administration and regulatory approach

The delivery system is predominantly **private providers**, with a small number of county providers. There are two major sectors: **fee-for-service** and **capitated integrated delivery systems**. Providers and individuals must choose to participate in one sector or the other.

Administration of the single payer system is by an elected health commissioner, public state board, and regional boards (including individuals representing providers, consumers, and employers). This structure is responsible for financial management of the system; establishing eligibility and benefits; negotiating reimbursement; and other functions. There are advisory groups, such as on immigrant issues, quality assurance, and clinical guidelines.

Current state **regulatory mechanisms** not supplanted by single payer provisions remain in place, e.g., agencies that oversee provider care quality, licensing, and financial soundness are largely unaffected. Coordination is anticipated with the single payer system, e.g., data collected on health care utilization and outcomes.

5. Benefits and copays

The benefit package is **comprehensive, with flexibility for cost-control** purposes. Specifically, **all medical care deemed medically appropriate** by the patient's health care provider, including: inpatient and outpatient care, diagnostic tests, prescription medications, durable medical equipment, podiatry, chiropractic, dialysis, medical transportation, rehabilitation, language interpretation, preventive care, long-term care services (institutional, home-based, and day treatment), mental health care, and dental and vision benefits.

There are **copays** of $5 outpatient and medications, $100 inpatient, room & board long term care. Individuals who meet Medi-Cal/Healthy Families income rules are exempted. Preventive care is exempted.

6. Financing mechanism

- **Current public health care spending:** public insurance (e.g., Medi-Cal and Healthy Families), federal insurance and service programs (e.g., Medicare, CHAMPUS, Indian Health Service, Veteran's Administration, Federal Employees Health Benefits Program); categorical programs (e.g., Ryan White CARE Act); state health care safety net funds (e.g., Realignment); and county safety net funds to the extent not needed for safety net services;
- **Private funds** intended for health services (e.g., part of retirement packages), to the extent covered individuals participate in the single payer system;
- **Billing** for services delivered to individuals covered by other programs.
- **Payroll tax** of 8% on employers (private and public), exempting firms with annual gross incomes of less than $75,000. These are likely to replace employer and employee payments now made to private insurers.
- **Personal income tax** for heads of households subject to California income tax, of about 0.3% of taxable income, and a state income surtax of 0.3% on net taxable income in excess of $250,000.

CAL-HEALTH
Helen H. Schauffler, Ph.D.

Cal-Health is based on Assembly Bill 32 (AB 32), which was introduced by Assembly Member Richman, Senator Figueroa, and Assembly Member Chan in December 2000. In 1999, 66% of California's uninsured were in families with annual incomes below 250% of the federal poverty level, representing 4.5 million Californians. Cal-Health will increase eligibility for health insurance coverage for all Californians with incomes below 250% of poverty, and will make private insurance more affordable for persons with incomes above 250% of poverty by permitting health plans to offer a low-cost standard uniform benefit package (SUBP) in the individual and small group market.

Objectives and Target Populations: The objectives of Cal-Health are:
1) To provide the uninsured with an easy, one-step streamlined process for enrolling in health insurance by coordinating the administrative functions of Healthy Families and Medi-Cal and providing for accelerated enrollment in these programs under Cal-Health. Existing Medi-Cal and Healthy Families income and resource methodologies, other eligibility rules and applications, enrollment, retention and seamless bridging procedures will be simplified, streamlined, and coordinated under Cal-Health.
2) To target outreach through schools and health care facilities. Every pre-school and public elementary and secondary school will inform the parent or primary care taker of every enrolled child at least once a year about Cal-Health and an application may be submitted at the school. All licensed hospitals, clinics and other health care facilities will inform all uninsured patients seen or admitted about Cal-Health and may enroll them at the site of care using an automated enrollment system with paperless verification. Providers who enroll uninsured adults and children at the point of service will be reimbursed for services. It is estimated that the state will realize approximately $94 million in administrative savings from accelerated enrollment.[1]
3) To expand eligibility to parents under the Healthy Families program to those with family incomes between 200% FPL and 250% FPL. If fully implemented in 2002, it is estimated that 66,000 parents would newly enroll along with 51,000 of their children.[2]
4) To create an standard uniform benefits package (SUBP) that will be more affordable than the current products available in the market, which private carriers may sell in the individual market for those with incomes above 250% of poverty and to small businesses. (50 or fewer employees). It is estimated that 59,000 Californians would be newly covered by the SUBP.[3]
5) To expand coverage to low-income, non-custodial adults through the Medi-Cal program for persons with incomes at or below 133%of FPL and who are not currently eligible for other programs, and through Healthy Families for persons with incomes between 133% and 250% of FPL and who are not currently eligible for other programs. If the federal waiver is approved, 1.7 million Californians would be newly covered by this expansion.

Eligibility: There will be NO assets test for adults and children in Cal-Health. Persons covered by employer-sponsored health insurance in the six months prior to application for coverage will not be eligible for Cal-Health.

Administration and State Regulation: The state will administer the Cal-Health program and will coordinate Cal-Health with Healthy Families and Medi-Cal. Cal-Health will create a single,

---

[1] The Lewin Group, HSBM 2002.

[2] The Lewin Group, HSBM 2002.

[3] The Lewin Group, HSBM 2002.

simplified and streamlined process for the determination of eligibility and enrollment with one portal for entry for all Californians eligible for either program, which will reduce administrative costs. There are two major Federal and State legal or regulatory changes that are required to implement the Cal-Health program. The first is that the state will need a federal waiver to expand the Healthy Families program to parents with incomes up to 250% of FPL. Second, the state will need to obtain approval for a unique federal waiver request that would waive the long-standing requirement of budget neutrality to the federal government to expand Medi-Cal and Healthy Families to low-income non-custodial adults. In addition, by expanding eligibility for the Medi-Cal program, which is currently determined by the counties, this option imposes a state-mandated local program by expanding the scope of those duties.

Health Benefits: Persons enrolled in Healthy Families will have health care coverage for the services mandated by the Healthy Families program. Similarly, persons enrolled in Medi-Cal will have access to the health care services mandated by the Medi-Cal program. Persons who purchase private coverage with the SUBP will have coverage for hospitalization, outpatient visits, preventive care, ambulance services, dialysis care, maternity care, mental health care, emergency and out-of-area care, family planning, hospice care, health education, imaging, lab tests and special procedures, reconstructive surgery, and transplants. In addition, coverage with limits will be offered for physical, occupational and speech therapy, multidisciplinary rehabilitation, and home health care. Two SUBPs will be offered: one for persons who are 19-34 years, which reflects their lower health care needs and utilization, and one for persons who are 35-64, which reflects their greater health care needs and utilization.

Financing Mechanisms: Financing for this option will come from both the state and federal governments for Medi-Cal and Healthy Families. As the previously uninsured population enrolls in Cal-Health, 70% of the average per capita cost of safety net funding for medical care per uninsured person will be transferred to help finance the state and federal share of Cal-Health (this will not include Federal DSH funds). Over time, the funding levels for the safety net to provide care to uninsured persons will increase as it retains both its current funding levels for persons who remain uninsured plus 30% of the funding from those who were previously uninsured and have enrolled in Cal-Health. Over time, this option assumes that the State's need to directly subsidize the health care safety net providers, including county health programs, community clinics, and DSH hospitals, will decline and that these providers will receive a more stable and generous source of revenue through insurance payments, as Cal-Health will significantly increase the number of previously uninsured individuals seeking medical care in these facilities.

Impact of Cal-Health on Costs and Coverage: If the federal waiver for non-custodial adults is NOT approved, Cal-Health will extend new coverage to 444,000 Californians at a net savings to the state of $40 million.[4] If the federal waiver for non-custodial adults IS approved, Cal-Health will extend new coverage to 2.12 million Californians at a total net cost to the state of $857 million.[5]

---

[4] The Lewin Group, HSBM 2002.

[5] The Lewin Group, HSBM 2002.

CHOICE
Helen H. Schauffler, Ph.D.

Objectives: The objectives of the CHOICE Program are to 1) cover approximately 95% of California residents, regardless of legal status, 2) increase enrollment in Healthy Families and the Medi-Cal for those who are eligible but not enrolled, through mass media campaigns, extensive community outreach, and accelerated enrollment, 3) to increase patient choice of physicians and health care facilities to a statewide fee-for-service network and organized delivery systems (ODS) , 4) to make health insurance more affordable for individuals and families, and employers, 5) to provides a reasonably comprehensive standard set of benefits to all enrolled Californians, 6) to provide fair payment to all health care providers in the CHOICE Network using Medicare payment rates, regardless of the patient's source of financing, 7) to increase efficiency in the administration of health insurance coverage by improving the quality of health care, bulk purchasing pharmaceuticals and medical equipment, and streamlining administration, and 8) to maintain and improve the health of the people of California and to meet their medical care needs by: providing coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition, returning medical care decision-making to health care providers and their patients, and holding health care providers in the CHOICE Network and ODS contracting with the CHOICE Program accountable for quality and costs.

Target Population: The primary target populations include: working Californians and their non-working dependents, and those who are eligible for public programs but not enrolled. Californians under age 65 who reside and work in the state and their non-working dependents, regardless of race, age, gender, religion, ethnicity, sexual orientation, immigration status, health status, or income will be eligible to enroll in the CHOICE Program. Workers include full-time, part-time, seasonal, contractual and the self-employed. The target population also includes persons enrolled in publicly funded health insurance programs, including Medi-Cal, Healthy Families, AIM, MRMIP, and Medicare for the elderly (under a CMS demonstration program).

Eligibility: Non-elderly (0-64) Californians who meet three criteria are eligible to enroll in the CHOICE Program: 1) presently reside in California with the intent to remain, 2) ages 0-64 and not covered by Medicare, and 3) meet one of the following criteria: a) worked in California (or the non-working dependent(s) of eligible workers) for at least 3 months out of the last 12; b) eligible for COBRA health benefits; and c) receiving state unemployment benefits. Individuals and families who enroll in CHOICE will have coverage for one full year, with annual renewal guaranteed, conditional on continued payment of the income-based share of the premium. Worker premiums are collected through automatic payroll deduction. Individuals can self-certify their eligibility with paperless verification and may allow an application for enrollment to be submitted by a health care provider while they are in a hospital, clinic, or other health facility.

Mechanisms for Expanding Coverage: The CHOICE Program reforms California's health care system through the voluntary actions of individuals and employers based on their preferences and economic incentives. All Californians eligible to enroll in CHOICE will have two options for coverage: 1) get their medical care from any licensed health care professional or facility that elects to participate in the statewide fee-for-service network for provision of covered services, and 2) enroll in any state licensed ODS (including group-model HMOs, County Organized Health Systems (COHS), or non-commercial Local Initiative (LI) plans) that elects to contract with the CHOICE Program. In addition, the CHOICE Program will work with DHS in contacting hospitals, and outpatient facilities, as well as preschools, and public elementary and secondary schools to ensure that persons seeking medical care, and who are eligible for state programs (Medi-Cal, Healthy Families, AIM), enroll and receive health insurance benefits. It is

estimated that within one year of adoption of the CHOICE program 71% of the non-elderly population will enroll in CHOICE and 94.4% of all California residents will have coverage.[6]

Financing: The CHOICE Program is fully funded. Existing sources of financing include state funds for MRMIP and AIM; the State and Federal share-of-cost for those eligible for Healthy Families and the Medi-Mdi-Cal; the Medicare+Choice capitation payment for the elderly; 80% of the per capita savings in the State's direct subsidies for indigent medical care resulting from coverage of persons previously uninsured (does not include Federal DSH payments and increases per capita State funding to the counties for indigent medical care for those who remain uninsured). New sources of financing include a wage-based worker monthly premium, a quarterly employer marginal payroll tax that varies by firm size and total payroll (with a refund for workers covered by an employer-sponsored plan); three public health taxes (on tobacco, soda, and moving violations); a 0.25% increase in the state sales tax; a 1.25% increase in the state income tax; and funding from the proposed NAFTA Social Integration Fund for Mexican citizens working and residing in California.

Administration and Regulation: MRMIB will administer the CHOICE Program. The CHOICE Program involves no state mandates of individuals, no new Federal waivers, and no ERISA waiver. Rather, it restructures current payment mechanisms to cover currently uninsured Californians. Eligibility requirements for income, residency, and work will be determined by a self-certification process with paperless verification and no assets tests. The CHOICE program will contract directly with licensed health care professionals and facilities in the statewide CHOICE Network whose performance will be assessed on quality and cost. The State will offer tax incentives to insurance carriers and health plans to partner with large multi-specialty groups in exclusive arrangements to form new group model HMOs. Regulation of the coverage offered by employers will not be affected by this proposal. The Departments of Managed Care and Insurance will continue to regulate health care service plans and disability insurers, respectively.

Benefits: CHOICE provides coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition. The Kaiser Foundation Health Plan standard benefit package in the large group market is the initial benchmark for health benefits under the CHOICE Program. New benefits will be added over time by determining which treatments are most effective in maintaining and improving health, as well as which are relatively cost-effective in improving health outcomes. CHOICE offers a more rational framework determining what benefits will be covered. Benefits will be selected conscious of the trade-offs between cost, quality, access and choice. An independent panel of experts will be established to advise the CHOICE Program on the treatments or drugs which should be added or removed from the standard benefit package.

Quality: Physicians participating in the statewide CHOICE Network and participating ODS will be required to report on both quality and cost metrics, and to participate in quality studies. In addition, CHOICE enrollees will be provided information on Centers of Excellence for specific conditions to improve their quality of care. ODS, health care facilities, and physicians participating in the CHOICE Program will be offered financial incentives for improving their performance on quality indicators, preventive care and disease management.

---

[6] The Lewin Group, HBSM 2002.

CALIFORNIA HEALTH SERVICE PLAN

Ellen R. Shaffer, PhD, MPH

Major Objectives

Through the California Health Service Plan, the public would both finance and administer the health care delivery system. Providers would be employed by the state to provide health services to all California residents. Savings would be sufficient to cover all California residents for comprehensive services.

Accountable public authorities that involve communities and health care workers in decision-making would integrate fragmented sources of financing, coordinate the delivery of services, and improve population health. The plan's objectives are:

- **Improve population health and quality of care**
  - Designate public authorities accountable for achieving, documenting and reporting improvement
  - Involve health care workers and communities in strategic planning
- **Coordinate and integrate delivery system**
  - Public owns health facilities, employs health care workers
  - Allocate health care resources where needed
    - Independent "base closure" committee to determine hospital capacity
    - Greater support for current "safety net" providers
- **Align relationships among providers, patients and payers to create valued outcomes**
  - Financial incentives
    - reimburse health care workers by salary; incentives tied to performance
    - encourage ethical professionalism
  - Organizational incentives: Involve health care workers and communities in setting quality targets, and other aspects of decision-making
- **Focus on supply side (providers, payors) to control costs**
  - Sharply reduced administrative waste: single payment source; no billing from hospitals or clinicians
  - Annual spending increases limited to increase in Gross Domestic Product
  - Increase percent of primary care physicians from current to 33% to 55%, reduce percent of specialists
- **Stable, progressive funding**
- **Universal coverage**

Target populations and eligibility

- Universal coverage, including the undocumented
- Residence requirement: 3 months
  - Emergency services covered in the interim
  - Reciprocal coverage for short term visitors with other sources of insurance

Mechanism for expanding coverage

Legislation to enact California Health Service Plan would authorize the state to finance and provide services to all Californians. Outreach programs would encourage enrollment.

State and local health departments would engage in strategic health planning, cooperating with providers and communities to improve health status.

Delivery system administration and regulatory approach

The California Health Services Administration would set policy for and coordinate the work of:

- California Health Service (CHS): delivers hospital and home health services, and most primary care.
    - Office of Accountability develops operational standards, advocates for patients.
    - Office of Reimbursement sets payment rates and pays providers
    - Office of Community Health Services provides home health services, and community outreach and health education for vulnerable populations
- Department of Public Health (DPH): sets policy for and coordinates population health and public health programs.
- Office of Statewide Health Planning and Development (OSHPD) collects and reports data to support strategic planning by CHS and DPH.

Patient advisory boards provide patient perspectives on organizational, access, and quality issues, and educate and communicate with patients. Members are elected at the community level, subject to conflict of interest rules, and work half time for the board.

Benefits

Inpatient and outpatient hospital care; prescription drugs; durable medical equipment; mental health; dental care; vision care; limited home health care; care coordination. Office visits to health care professionals working in salaried group practices, including physicians, advanced practice nurses, physician assistants, mental health and social service providers, dentists, chiropractors, acupuncturists, podiatrists, and allied health professionals.

Financial models shows costs for the plan both with and without coverage for long term care and eyeglasses. Alternative medicine provided by practitioners outside of group practices would not be covered, but could be available privately.

Copayments

There are no individual copayments. Copayments are likely to reduce use of both necessary and unnecessary services, especially for low-income residents. The system relies on supply-side financial incentives, and organizational features including increased availability of primary care and allocation of capital resources, to assure appropriate and affordable utilization.

Financing

Stable, progressive funding, with the least burden on individuals and employers with lowest incomes.

- Payroll tax
- Tobacco tax
- Income tax to supplement if needed (not projected to be necessary)

"CAL CARE" SINGLE PAYER PROPOSAL

Principal Authors: Judy Spelman, RN and Health Care for All-California

What is Single Payer?

- Single Payer is a universal health finance and administrative system. The State of California establishes a health insurance plan that covers all California residents. The plan replaces all other health insurance plans, public and private. The plan is funded by taxes instead of insurance premiums. Plan is administered by single state agency.
- Universal care is affordable because money saved by streamlining administration is shifted to health services.
- Universal care is sustainable over time because the rate of growth of health care spending is limited to the rate of growth of California GDP.
- Universal care is sustainable over time because cost inflation is controlled through global health care budgets with spending ceilings, state purchasing power to win discounts on pharmaceuticals, medical supplies and emphasis on primary and preventive care.
- Quality of care for all is improved through equitable distribution of resources including high technology, state wide health care planning, coordinated data collection and analysis, return of decision making to medical practitioners and linkage of health research and innovation to California's health care needs.

Cal Care: Major Objectives and Policies

Universal Coverage

All California residents covered from cradle to grave.
No exclusions for "pre-existing" conditions.
Insurance not lost with job change or job loss.

Sound Finance

Universal coverage for less than we now spend on healthcare through savings on administration, purchasing discounts and statewide health planning.

High Quality Care

Doctors decide on appropriate care, not insurance companies or the government.
Everyone chooses his or her own doctor.
Enforceable quality of care standards, including cultural and linguistic standards.
Special needs of people with disabilities met.
Health professional safe-staffing ratios.
Consumer advocate in each county.
Incentives to increase supply of nurses, including on-site child care.
Well-funded, coordinated development of advanced health technology.
"Risk-adjusted" budgets ensure adequate funds for high quality care.

Affordable Care

All Californians pay fair share. Health care costs for most Californians reduced.
No increase in costs when you are ill.

Good for Business

Business opportunities through public-private partnerships.
Business opportunities through expansion of market by 7 million Californians.
Levels playing field: Makes health payroll tax an operating expense for all businesses.
Stabilizes health system inflation.
Maintains prevailing wages and working conditions in public-private partnerships.

Delivery System
Delivery of care is private. All current providers may participate
Patient choice of provider. Includes Kaiser, other HMOs as well as individual providers.

Benefits
Comprehensive benefits: No co-pays. Includes: preventive, outpatient, hospital, emergency, podiatry, hospice, skilled nursing facility, personal behavioral therapies such as stress management, smoking, substance abuse cessation and obesity control, specialists with referral, mental health parity, durable medical equipment, dental, vision, long term, in home care, reimbursement to family caregivers, alternative and complementary care, full pharmaceutical coverage reform of Workers' Compensation. No loss current benefits.

Governance
Elected State Health Commissioner. Appointment through public process of State Health Commission members and County Health Officers. Single State Health Agency administers system. Consumer Advocate in each county. Public accountability.

Finance
Current federal, state and county health dollars, payroll tax (6.1% employer; 3.6% employee), tobacco tax ($1.00 per pack), alcohol tax (15cents/can beer; 32 cents/bottle wine; 48 cents/bottle champagne; $5.00/bottle distilled spirits) sales tax (1/4 cent) and surcharge on non-payroll income (2.8%).

Transition: Two-year transition period

INSURING CALIFORNIA'S UNINSURED

Lucien Wulsin, Jr., Peter Long, Roohe Ahmed, Megan Hickey, Jan Frates, Van Ta, Talia Silverman

Insure the Uninsured Project proposes that California begin to cover its 6.8 million uninsured through both public and private initiatives. Under our proposal California's lowest income uninsured will be covered by expanding Medi-Cal and Healthy Families; those with higher incomes will have improved access to and better affordability of private coverage.

- §1115 waiver to cover low-income adults,
- Seamless coverage for those enrolled in public programs,
- Refundable tax credit to increase the offer rate for employers with low-wage workforces and purchasing credit to increase take up by low-wage workers,
- Refundable tax credit/voucher and insurance reforms to increase coverage of the flex workforce (temporary, part time, seasonal, contract workers and the self-employed) who are not typically offered coverage through an employer.

This would give all California residents who cannot afford health coverage opportunities to secure affordable coverage through their employer, the individual market and/or public programs. It would lay the foundation for universal coverage if California can develop the political consensus for a single payor system or for a combination of individual and employer mandates to achieve universal coverage.

Major Objectives:

- Increase in low-wage working adult coverage
- Increase in small employer offering
- Increase in opportunities for affordable private coverage
- Increase in federal financing of care for California's uninsured
- Improvements in delivery systems for uninsured
- Increased flexibility and support for pioneering safety net clinics and hospitals
- Increased coverage opportunities for immigrants
- Programmatic simplification

Target Populations:

The proposal seeks to finance coverage of the uninsured with annual incomes up to $35,000 for an individual and $70,000 for a family.

1. Below 133% of the federal poverty level (FPL) [up to $11,900 for an individual], we expand Medi-Cal coverage through a Medicaid waiver.
2. Between 133 and 200% of FPL (between $15,440 and $23,220 for a family of two), we expand Healthy Families and affordable private coverage.
3. Above 200% of FPL we propose increasing private coverage.

Mechanisms for Expansions:

We would expand public and private coverage through a federal waiver, refundable tax credit, premium subsidies and increased use of group purchasing.

1. *Medi-Cal and Healthy Families managed care coverage for low income adults.*
   - In *Two Plan* counties, adults with incomes below the poverty level would choose between the county Local Initiative and its commercial competitor.
   - In *Geographic Managed Care* counties, adults with incomes below the poverty level would choose among contracting managed care plans.
   - In *County Organized Health System* counties, adults with incomes below the poverty level would be eligible for the COHS.
   - In *Small Counties* without mandatory managed care, adults with incomes below the poverty level would be eligible for Medi-Cal fee-for-service coverage.
   - Low income adults with incomes above the poverty level would be eligible for Healthy Families plans.

2. *Employment-based coverage for uninsured low-wage workers and families*.
   This proposal uses refundable tax and purchasing credits to increase small employers offering and low-wage workers accepting coverage.

3. *Purchasing pools, individual market reforms and vouchers for flex workers*.
   Flex workers (nearly half of uninsured workers) are in jobs not typically offered health coverage by an employer. This proposal would use insurance market reforms and a sliding scale premium subsidy to increase flex workers' coverage through the individual market and group purchasing entities.

Health Benefits Package:

1. Medi-Cal benefits for low income adults below 133% of FPL.
2. Healthy Families benefits for low income adults over 133% of FPL
3. Knox Keene basic benefits plus prescription drugs for persons with tax subsidies.

Financing:

Federal matching for adults

The proposal seeks a federal §1115 waiver to cover adults without Medicaid or Healthy Families linkage. We recommend that California meet the federal waiver's cost neutrality test by implementing managed care for disabled adults, consolidating and simplifying coverage and, to some extent, transforming Medi-Cal's institutional subsidies into coverage.

State and county financing for care to low income adults shifted

This proposal shifts state and county financing, which pays for care for low income adults, to purchasing coverage as individuals enroll in the new program.

Taxes

We do not see a need for a tax increase to finance our proposal, as we propose to use current state and county and new federal funding to finance the expansion. To the extent that new revenues are required, we believe that a small tax on providers and health plans would generate more than adequate revenues. This approach succeeded in financing expansions in other states such as Minnesota, Florida and Tennessee.